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THIS JOURNAL IS MANUFACTURED UNDER WARTIME CONDITIONS IN CONFORMITY WITH ALL GOVERNMENT REGULATIONS CONTROLLING THE USE OF PAPER AND OTHER MATERIALS

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Bulletin of
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THE WAR AGAINST FEAR AND HATE*

BY KARL A. MENNINGER, M.D.

While the greatest war in history is in progress, we are met together to celebrate the founding of a psychiatric hospital, marking an epoch in what is really a much greater war, a much longer war, a war that has been going on for centuries.

In the early 1820's an undistinguished but energetic young woman by the name of Dorothea Dix established a private school in Boston. At that time the regular grammar schools of Boston were "dens of cruelty kept by tyrannical men who were proud of their different switches, rattans and rawhides, and regarded them," said Edward Everett Hale, "as the only real instruments of education." Perceiving a need, Dorothea Dix established her school along different principles.

After fifteen years of it, when she was 34, she suffered an illness, she gave up her school and went to England. Here she (probably) met Dr. Samuel Tuke, the son of William Tuke, the Pinel of England, whose work of fifty years before had gone without influence upon the people of the hospitals of the United States.

On a raw March Sunday in 1841, five years after the onset of her illness, the recovered Dorothea Dix visited the East Cambridge jail in Boston to teach a Sunday School class. Among the prisoners were some mentally ill persons. All were being treated with an equal degree of barbarous cruelty and neglect.

The perception by Miss Dix of the suffering of these unknown prisoners and patients in the East Cambridge jail led to a declaration of war against fear and hate and human cruelty that culminated in the present day institutional psychiatry of America, of which we now have reason, I believe, to be proud.

In the course of her investigations of existing conditions, Dorothea Dix came to Rhode Island in the spring and summer of 1843. There were at that time no provisions in this state for the care of the mentally ill, public or private. "Justices of the Peace continued to commit to the county jails according to law, 'furiously mad persons dangerous to the peace and safety

*Read at the ceremonies of the Centennial Celebration of Butler Hospital, Providence, Rhode Island, May 10, 1944. Approximately simultaneous publication here and in the *Rhode Island Medical Journal* is by arrangement of the respective editors.

of the good people....' Less violent persons were confined at home, boarded out, or provided for in the local almshouse."

It was in Rhode Island that the celebrated case of Abraham Simmons was discovered. He was a psychotic patient confined in a stone roofed, stone floored cell, tethered to the stone floor by an ox-chain: " 'Sometimes he screams dreadfully and that is the reason we had the double walls and the two doors,' explained the woman who had conducted Miss Dix to Simmons' cell. 'His cries disturb us in the house.... My husband sometimes of a morning rakes out half a bushel of frost, *and yet he never freezes!*'

"'How long has he been here?' inquired Miss Dix, according to her biographer, Helen Marshall.*

"'Oh, above three years,' was the answer."

Simmons was by no means an unusual case but for some reason or other the inhuman conditions of his confinement made a particularly deep impression upon Miss Dix and upon responsible citizens of Rhode Island to whose attention she called them. Among these was Nicholas Brown, who had bequeathed $30,000 to be used toward the erection or endowment of a retreat as had been provided by an act of legislature. Brown died in 1843 and the Rhode Island General Assembly issued a charter for such a retreat in January, 1844. The same year Cyrus Butler gave $40,000 on condition that an equal sum be subscribed.

"Miss Dix prepared an article ... for the *Providence Journal*, and then went to Newport where the legislature was sitting. When members of the legislature called to talk with her about the proposed hospital, she pressed the Simmons case and told them how the town had promised ten months before to move him to a hospital but had taken no further action. She had come to Newport, she said, to secure his removal; she could not take him away without the consent of the town but the legislature might intervene.

"Mr. Updike, one of the legislators, was greatly moved and declared that the assembly should interpose at once. He went to the house of representatives and made a speech that roused everyone. A member from Little Compton then arose and announced the death of Simmons. There was an awkward pause—mercy had come too late. Finally another member arose. There were other insane paupers in Rhode Island; he moved that a committee be appointed to investigate their condition....

"Miss Dix's next visit to Rhode Island saw the hospital fund oversubscribed."

You know the rest. These grounds were then selected, these buildings planned, these walls constructed, these rooms equipped. A competent

*Marshall, Helen E.: *Dorothea Dix. Forgotten Samaritan.* Chapel Hill, University of North Carolina Press, 1937. This is the source of the data here given regarding Miss Dix.

staff was enlisted. Miss Dix had won a battle, and she had just begun. The war was to go on against fear and hate and prejudice and bigotry and selfishness and meanness and the dangerous lusts. By lusts I do not mean the yearnings associated with sex, which civilization has whipped and shackled into comparative innocuousness; I mean the lust for power, the lust for accumulation, and the lust for cruelty. It is these lusts which make men sick and which bring suffering and sorrow and disability. It is the war against them that constitutes the great war of our times, if we could only know it, not the bloody conflict of flesh and metal that our daily papers record in the headlines each morning. The war I am thinking of is fought by guerrillas and underground patriots, in unspectacular actions, in secluded places—like this. Like the war abroad, this silent war at home has its tragedies, its screams, its bloodshed and its sorrow. But instead of great daily headlines for all to see, there are only occasional modest reports in stodgy medical journals; instead of thousands of tons of explosives, there are only many quiet hours of counsel and comfort; instead of campaigns of destruction, there are campaigns of planned rehabilitation; instead of billions of tax money, there are only a few thousand from private and state benevolence.

Right here where we stand and sit, within these walls, hour upon hour, day after day the battles of this war have been fought, and are being fought. Commanded by a wise, far visioned general*, who sits beside me here on the rostrum, and by his illustrious predecessors† listed on your programs, company after company of soldiers have taken their posts. Volunteers, replacements, technicians, executives, Grey Ladies, white ladies—they are all here—just as in that other army. Spurred by their example of devotion, service, and scientific idealism, other companies have been organized, and new battalions formed in units reaching now from Providence in the Northeast to San Diego in the Southwest and from Seattle to the Keys. But the name of Butler Hospital, one of the first fighting units in the great war against fear and hate, remains in the front ranks.

If I have seemed to carry this figure of speech too far, I would like to speak directly to the point of proving that it is not a metaphor or simile, but a truth, a statement of fact. For after all, what is it that we do, we psychiatrists and our aides, in the cooperative group attack on mental illness represented by the modern psychiatric hospital? It is no longer—as in the times of Dorothea Dix—a matter of providing humane and decent living quarters, food and asylum from the curious and often cruel world, for a few hundred or a few thousand sufferers. All that is taken for granted today, thanks to Miss Dix, Clifford Beers and others. In those days that was about all that

*Dr. Arthur H. Ruggles.
†Dr. Isaac Ray, Dr. G. Alder Blumer and others.

one *could* do for the victims of these mysterious afflictions of the spirit. "What is it to be mad, but to be simply mad?" expressed what was then the universal consensus.

Today we know that to be mad is not simply to be mad. It may be to be overwhelmed with toxins, or to be invaded by microorganisms or to be subject to adventitious growths or perversions of glandular tissue. Or it may be to rebel against the injustices and inequalities of fate, or against the dishonesty and hostility of fellow workers or against the mistaken zeal or prejudice or misunderstanding of friends and family. Whatever its origin, madness can be and must be combated, and often it is best combated by the joint efforts of psychiatrists, nurses, physicians, therapists, and others that make a hospital.

Our conceptions of the nature of mental illness have run the gamut from the "brain-spot" hypothesis to the "mind-twist" hypothesis* and back again; today we are inclined to discard both in favor of conception that mind and brain and body and soul are inseparable, that disease is not the affliction of an organ alone, and mental disease not an affection of the brain alone, but that the total organism, the individual as a whole is integrated with a physical and social environment and can only be so considered, either in sickness or in health.

Thus *adjustment* becomes the keynote word of modern psychiatry, and failures in adjustment its chief province. This does not require that we discard what we have so painfully acquired in regard to anatomy and bacteriology and immunity and pathology and arsphenamine and penicillin and hydrotherapy and psychoanalysis. On the contrary, it requires that we use all this knowledge, all these approaches, all these methods—and at the same time seek for more. In this search, the little army at Butler Hospital has more than done its share.

It is to the implications of the modern psychiatric conception that I would particularly call your attention. If we assume that maladjustment is the province of psychiatry, are we not obliged to think of mental illnesses in broader terms than these connoted by "hallucinations" and "delusions"? What shall we say of the chronically unhappy, the self-elected Messiahs, the political agitators, the industrial misfits, the drunkards, the fire-setters, the Jew-baiters, the negrophobiacs, the double-crossing husbands, the cheating wives, the men who bribe government inspectors to pass defective cable to the war front, or the men who take these bribes? Where does the province of psychiatry, in such terms, end?

My own view, like that of Dr. Strecker and Dr. Zilboorg who have spoken here so eloquently, is that it does not end but that it extends. In theory, at least, all these maladjustments belong to psychiatry. I believe it

*Terms suggested by Ernest E. Southard.

is only through psychiatry, through the scientific study of human behavior, human motives, human instincts, human weaknesses, human failures that we can construct a durable or endurable civilization. I believe that only thus can we put a stop to the social diseases of the world—war, poverty, slavery, unemployment, panic, waste, famine, misery and perpetuated ugliness. For these social diseases are diseases of the individual personality. Louis Pasteur said that "Two contrary laws seem to be wrestling with one another nowadays, the one a law of blood and death ever imagining new means of destruction . . . the other, a law of peace, work, and health ever evolving new means of delivering man from the scourges which beset him." But it was Freud, the psychiatrist, who related these two contrary laws to the innate nature of human beings; it was he who recognized that the destructiveness of human beings is not the result of some passing fever, some incidentally occasioned accident in the normal course of life or some mysterious mob influence but the expression of a deep persistent instinct present in every individual. And it was also Freud who showed us that the impulse to live and love is likewise an instinctual endowment of human beings and a source of strength in opposition to the self-destructiveness. Die we must, ultimately, but in the meantime we can live, *if we can love.**

If we can love: this is the touch-stone. This is the key to all the therapeutic program of the modern psychiatric hospital; it dominates the behavior of its staff from director down to gardener. To our patient who cannot love, we must say by our actions that we *do* love him. "You can be angry here if you must be; we know you have had cause. We know you have been wronged. We know you are afraid of your own anger, your own self punishnent—afraid, too, that your anger will arouse *our* anger and that you will be wronged again and disappointed again and rejected again and driven mad once more. But we are not angry—and you won't be, either, after a while. We are your friends; those about you are all friends; you can relax your defenses and your tensions. As you—and we—come to understand your life better, the warmth of love will begin to replace your present anguish—and you will find yourself getting well."

It is not easy to maintain and to implement such an attitude and such therapy—but it is the program of modern psychiatry. It is, I know, the program of Butler Hospital.

Scientists, doctors, psychiatrists are not alone in seeking to solve the great problems of the individual or the problems of groups, of society. In a sense, *every* thoughtful person strives to do what he can to make the world a better place to live in. But the fact is that while we have made some progress, with the aid of religion, education, political science, economic

*These three sentences are taken from the author's book *Love Against Hate*, Harcourt Brace & Co., N. Y., 1942.

theory, social organization, we are still painfully far from our goal, and it seems to some of us that the application of science, psychological science, the science dealing with personality structure and personality function ought to yield more fruitful results. It has never been tried, really; even today we know far more about airplanes and radios than we do about human minds, and for the most part consider them (the former) more important.

This is why the battle waged by the psychiatrist against the hate and fear that have made his patient ill is at the same time a battle for human happiness and betterment. I think of this, and I believe my colleagues all do, when the long weary hours of work devoted to a single sufferer stretch out over monotonous, discouraging months and even years. It is not just for John Smith that I am patient and steadfast and unflagging—it is not just for him, or even for his family, or for science. It is for the world. It is for the better world that my children and my grandchildren shall live in.

This is my credo and my faith and my hope. This is why I am proud to stand and bear witness to my reverence for the founders of an institution that has carried on with this same faith for one hundred years, my gratitude to a community with the continued vision to make that possible, my inspiration from the lives and work of the men and women that have been and that are—Butler Hospital.

FREUD'S EARLY CHILDHOOD

By SIEGFRIED BERNFELD, Ph.D. and SUZANNE CASSIRER BERNFELD

1. INTRODUCTION

In his *Autobiography* Freud covers his early childhood with one sentence: "I was born on May 6, 1856, at Freiberg in Moravia, a small town in what is now Czecho-Slovakia. . . . When I was a child of four I came to Vienna." However references to this first period of his life occur in several of his writings. Collected and assembled in their proper order they, unexpectedly, form quite a coherent record of his first three years. When, at the age of forty-two, Freud turned his attention to the recollections of his childhood, he was not satisfied with their manifest content. He analyzed his memories, and even published some of the results. Though he did not intend to write the psychoanalysis of his childhood, and uses the material in various contexts and for various purposes—now, as an example of a certain mechanism, again, as the starting point for a general discussion, always casually and with restraint—it so happens that the broad lines of the development of the child and the essential traits of his personality do emerge.

The authors feel that this addition to Freud's *Autobiography* deserves to be brought together in one piece rather than being dispersed through numerous German volumes, some of the material not even having been translated. To the psychoanalyst these autobiographical fragments suggest two kinds of elaborations. First, implications by definition. If, for instance, Freud speaks of the rivalry with his father, in the Oedipus situation, the sexual wishes toward the mother are implied—though not specifically mentioned—since they are a factor in the Oedipus rivalry, as Freud defines the term. He expected to have psychoanalytical readers, thus these implications must be considered as parts of his written autobiography.

Second, interpretations, some of which may force themselves upon the mind of the psychoanalyst as being beyond doubt. Still, they are hypothetical, since they are based only on that selection of facts which Freud communicated incidentally, without attempting a "case history."

We have kept our elaborations strictly within the first group. We are presenting Freud's own analysis of his early childhood; we are not attempting to psychoanalyse him.

We have, however (in sections 2, 3, and 5), augmented the childhood story by facts from the environment in which they occurred. Our presentation approaches a narrative. The necessary philology is confined to the appendix.

2. FREUD'S BIRTH—FACTS AND LEGENDS

At birth, the baby Sigmund Freud had such an abundance of pitch-black ruffled hair that his young mother nicknamed him her "Little Moor." An old peasant woman prophesied to her that she had brought a great man into the world. The proud and happy mother, herself a descendant of a one-time famous scholar,* firmly believed in this prediction. It became one of the constantly repeated family stories, a part of the atmosphere in which the child grew up.

Thus, the hero's garb was in the weaving, right at the cradle. But Freud, the great debunker, was not willing to wear it. "Such prophesies," he wrote when he was over forty, "must be made very frequently; since there are so many happy mothers full of expectations, and so many old peasant women, who, their mundane powers having deserted them, turn their eyes toward the future. Also, no prophetess expects to be unrewarded for her prophesies."

When, in 1931, a committee of citizens of Freiberg (Pribor)† set out to install a memorial tablet on the house in which Freud was born, it was discovered that contrary to all the "Who's Whos" and to Freud's own statement, the city register lists Sigmund Freud's birth on the day of March 6, 1856. All these birthday wishes, then, addressed to Freud for seventy-five years, first by his family and then by his friends, and later by practically the whole world—did they all go wrong, missing by two months the right day?

Freud was not interested in this possibility. He only resented that somebody had tried to make him two months older. He had the date from his mother, "who ought to know best." The Committee accepted his view and engraved, as the memorable date in the history of the town: "May 6, 1856." So, although in cold Moravia the mother of a first-born boy might well have wished to celebrate his birthday in real spring; and, although we know the power of such wishes over reason and facts, we too, accept the traditional date.

The president of the committee, Mr. Benes—Director of the Worker's Health Insurance Institute in Pribor—explains the discrepancy as an error by the Czech clerk, who had to make the entry in the register in the German language, which the clerk neither knew too well nor liked too much. It so happens that the only name of a month with a similar spelling in German and Czech, is "May." This makes Mr. Benes' explanation not convincing.

Thus, upon entering into this world, the "Little Moor" caused one of

* Nathan Halevy Charmatz of Brody, Poland, who lived in the 18th century.

† Freiberg became a part of the Czecho-Slovakian Republic in 1918. At that time the old Czech name of Pribor(Przibor) meaning "Near the ruins" became official.

those odd slips, which as Professor Freud forty years later he was destined to explain.

3. THE SETTING

In March or May, 1856, Freiberg was a town of 4800 Germans and Czechs, belonging to the Austrian Empire, or more precisely to the Margravate Moravia, in the district of Neutitschein, 150 miles northeast from Vienna. It was situated in the rolling foothills of the Carpathian mountains—then a peaceful pastoral countryside—half a mile from a dense forest, on a steep bank over the Lubina—a little trickle in summer, but broad and tearing in spring. On a hill, inside the town, the steeple of St. Mary's Birth Church rose almost 210 feet high, and had the best chimes in the province. In the center of the town was an unusually large market square, surrounded by arcades of well-built houses. One of these houses conspicuously displayed a memorial of the Thirty Years' War. In those glorious days, the bellicose shrewdness and tough endurance of the citizens had become proverbial: "Brieg, Freiberg und Bruenn make Swedish armies thin." The coat of arms, granted the town "for valor," shows on a field of gold and red two big, vicious-looking pruning knives.

Somewhat off the market place and close to fields and pastures, at 117 Schlossergasse, Jacob Freud lived comfortably with his family. The home, built around 1800, was extremely simple—a detached, rather small, two-story house, without ornamentation, constructed of plastered bricks, with a slate roof.

In 1855, Jacob,* then over forty years of age, married a second time. He married Amalia Nathansohn,† who was not yet twenty. The following year Sigmund was born.

At that time Jacob Freud was already a grandfather. Emanuel, the eldest of the two sons of his first marriage—then in his twenties—had a son, John, one year of age, and a newborn daughter, Pauline. Both of these families lived in Freiberg as a closely knit unit.

From the very beginning, then, the position of Sigmund was full of complications and of paradoxes. He was the eldest son of this marriage, yet at the same time he was the youngest child in his family group. He was an only child, but for all practical purposes he had an older brother and a twin sister; and to confuse matters all the more, these sibling equivalents were his nephew, one year older than he, and his niece, of approximately his own age. Thus his privileges as eldest son and his benefits as only child and youngest boy became uncertain. He had to fight for them. Even his authority as an uncle was in question.

* Born 1815; died October 23, 1896.

† Born August 18, 1835; died September 12, 1930.

Sigmund's young mother, half-brothers and sister-in-law were approximately the same age; his father was old enough to be his maternal grandfather. In fact, Jacob was the grandfather of Sigmund's closest brother-like friend and rival, John. In relation to his father, Sigmund was rather "in the third generation," as Phillip, the younger of his half-brothers, put it twenty years later to the student Freud, who felt the expression to be very illuminating. Sigmund's relations to his mother were natural and simple. She was his. She was proud of her son. She was affectionate, and she nursed him. There was a Nanny to help with the housework and the care of the child.

In this setting, then, the "Little Moor" lived his first three years "as the happy child of Freiberg, the first-born son of a youthful mother," as Freud summarized his earliest childhood in the letter which was read at the unveiling of the tablet at the house of his birth.

4. THE FIRST THREE YEARS

In Freud's story of his childhood, as he refers to it at various times in his writings, one of the *personae dramatis* is not mentioned; his sister-in-law, the mother of John and Pauline. In fact very little is said about his own mother, but we are made to feel that there was a mutual, deep attachment between mother and child.

We learn a good deal about the Nanny, "that prehistoric old woman." She was ugly but very clever and efficient, and she often treated him less than pleasantly. She scolded him bitterly and most likely even spanked him when he did not show sufficient appreciation for her standards of cleanliness. Yet he gave her his love and all of his pennies. He missed her a lot when she later disappeared.

We also get a vivid picture of the alternately friendly and hostile relations between the young uncle and his older and stronger nephew John. They were inseparable. They loved each other and fought each other. Occasionally John was a tyrant who mistreated the younger playmate. But the little uncle had courage and knew how to stave off permanent submission. He hit back. For years the family remembered the speech of exculpation with which the two-year-old retorted when his father called him to account: "Why did you hit John?" "I hit him 'cause he hit me!"

Freud relates only one incident in which Pauline appears. It all happened on a gently sloping green meadow, covered with "beautiful yellow flowers." On top of this slope was a farmhouse in front of which a peasant woman, wearing a kerchief, and Nanny, chatted busily with each other. On the slope the children were playing peacefully, picking the yellow flowers. Pauline had collected the prettiest bouquet, when suddenly uncle and nephew, as if by premeditated agreement, jumped at her and grabbed

the flowers out of her hand. Crying, Pauline ran up the slope, where the peasant woman, as consolation, gave her a large piece of dark bread. As soon as the boys saw this, they threw their booty away and they, too, hurried up to the house and demanded their share of the bread. And they got it. The peasant woman cut the pieces of bread for them from the loaf with a long kitchen knife. "Never has bread tasted better."

Freud tells us a few significant things about his relations with his father. They would go into the "beautiful forest" together and as soon as the little boy could walk, he would try to toddle off on his own. He grew to admire his father as the wisest, wealthiest, and most powerful man he knew. In fact, Father Freud was the ultimate judge at the top of the hierarchy of authorities: Father, Emanuel, Nanny, Mother, John. He exercised his patriarchial powers in a gentle and kind way. Still, he appears as the frustrating and censoring force, as for instance when he interfered in the bickerings between grandson and son, or again, in a very early incident when the Little Moor, impelled by sexual curiosity, intruded into his parents' bedroom and was driven out by his father's emphatic command.

The reaction to this authority was neither submissive nor hostile. One wants to say that the boy displayed a manly attitude towards his father, as in the exculpation speech, or in that scene, at the age of two, when he occasionally still wet his bed, and when reproved for doing so, consoled his father by the promise to buy him, in Neutitschein, the district capital, a beautiful new red bed.

In the Little Moor's life there were, of course, the usual tragedies of childhood; a soiled bed and an occasional nightmare. Also the following highly moralistic accident: alone in the pantry, the little boy climbed up on a footstool to get from the table or chest, something good and forbidden, all for his very own. The footstool tumbled over, and its edge struck the child behind the lower jaw. It might well have knocked out all his teeth. The wound bled profusely, but the one-eyed family doctor sewed it all together again. A scar persisted as if to remind the culprit that he had been served right.

Freud's half-brother, Emanuel, twenty years his senior, was one of the most important persons in the boy's mental and emotional development. He appears as the leading figure in the decisive last six months in Freiberg, as Freud was becoming three years of age. Of this period Freud recalled only one episode—a scene that was singularly vivid in his mind; "I see myself in front of a chest," he wrote when he was forty-two, "the door of which was held open by my half-brother. I stood there demanding something and screaming. My mother, pretty and slender, then suddenly entered the room, as if returning from the street. I am tempted to explain this picture as the memory of a hoax by my elder brother, which was

interrupted by my mother." But his self-analysis reveals that the memory was a screen, covering the two following traumatic events.

The Little Moor was just two and a half years old when his mother gave birth to another child—a girl, Anna.* He was not at all agreeable to this addition to his family. He did not know the why's and how's and wherefore's of it all, and he worried distrustfully lest more little sisters might appear.

Immediately thereafter, and without forewarning, Nanny disappeared. She had been caught at extensive stealing and put into jail by the resolute Emanuel. The Little Moor was doubly distraught, for added to his grief at losing Nanny was worry about the other sudden change. He knew nothing for certain but he sensed that his brother had played some sinister part in Nanny's disappearance. He asked him where she was. Evasive and witty as he was, Emanuel said: "She is cased in," and that was final. Of course, this remark could not pass as an answer. It simply added another riddle.

Thus the child was left to his own observations, imagination and powers of deduction. He reached a firm and definite, though incomplete, conviction—a theory, as Freud would say: Sister came out of mother's womb; he who had made Nanny disappear, Emanuel, had cleverly slipped the baby into mother.

The screen memory expresses this theory in the language of dreams and of the symbolic thinking of early childhood. The chest symbolizes the mother's womb; the slender figure of the returning mother alludes by contrast to the deformation of pregnancy. What the child had demanded so urgently was to look into the chest; and he screams at finding it empty. It is the brother, the knowing culprit, who knows all too well how to handle chests, to whom the child addresses his wish.

In the German original, Nanny's disappearance is neatly condensed with the episode of mother's baby. Emanual evaded a direct answer to the child's question by using the ambiguous German expression, "*Sie ist eingekastelt,*" which to any adult, would have meant, "She's in prison." The child understood it more literally, "She is in a chest," or as we said, "She is encased."

The "theory" of course did not aim primarily at intellectual satisfaction. It sought a solution to the perplexing libidinal conflicts created by the changes. From now on the child had to live with an intruder and he had to learn to love her, or to say the least, not to hate her; he had to go along without the give and take of Nanny and had to remain within the standards of civilization free from her supervision.

* Between Sigmund and Anna was a boy, Julius, who died when eight months old. Freud does not mention him in his writings.

But, as evidenced by the "theory," it seems that the boy's most urgent need was to live in peace with his father. In the "theory," the brother occupys the father place. Emanuel, not Jacob, is the powerful, all-knowing, all-tricking man, closest to mother and the creator of her child. Thus father is removed from the center of envy and jealousy. It may be that the boy loved his father more than he did Emanuel, or that he felt more threatened by him; in either case, stress was relieved by this shift of passions from father to brother.

Soon, it seems, the Little Moor learned to bear the existence of a sister. He discovered that the little Anna did not usurp his mother for very long. And as she came back "slender as ever," so she remained "the young mother of her first-born boy." Secure in this position, his grief about Nanny might have quickly vanished. After all, without her he could keep all his pennies and taste freedom.

The boy hardly had time to get accustomed to the new shape of things, when, at the age of three, he started on the long journey to a big, foreign city—to Leipzig. After a long trip by horse-drawn conveyance, he got his first sight of a railway; and, after a ride of many hours, he found himself divorced for good from the beloved home, the pastures, hill and forests of Freiberg, and from Emanuel, John and Pauline.

With this railroad journey, the recollections of childhood come to an end. At forty-two, Freud hardly recalled a single episode from the year spent in Leipzig and the following two or three years in Vienna. "Those were hard times, not worthy to be recalled."

5. THE BACKGROUND OF THE MIGRATION

The Little Moor did not realize that the sudden and disrupting change in his and his family's life was but one of the countless incidents in the steady industrialisation of Central Europe.

The peaceful little town with the beautiful name Freiberg (Free Mountain) now contained much of fight, despair and constraint. Cloth manufacture, which was its main source of income, had been on the down grade since 1835—and Jacob Freud was a wool merchant. Everywhere in Central Europe the introduction of machines threatened handwork increasingly. In the Forties the new Northern Railway, from Vienna to Germany and to Galicia, had bypassed Freiberg. This dislocated trade there and put increasing numbers of artisans out of business. Jacob Freud's business was directly affected. Furthermore, a serious inflation from 1852 on increased the poverty of the town, which, by the year 1859, was pretty well ruined. The Austro-Italian War in 1859 added its bit to make the future still more dark. For the Freud's, these facts made it seem advisable, if not imperative, to move away from Freiberg.

Very likely there were other equally good reasons. Since 1851, Austria had been under the political reaction of the Restoration, which even a Prussian general admiringly described as "completely Russian." This evil did not directly touch people who kept away from politics, as the Freud family likely did, even though Jacob and Emanuel were deeply impressed by the short awakening of freedom from 1848 to 1851. However, the shortlived revolution had produced another effect from which it was less easy to withdraw. The revolution had definitely established Czech nationalism as a power in Austrian politics and consequently had fanned the Czech hate against the Germans, the ruling class in Bohemia and Moravia. Now the Jews, who in language and education were German, became the objects of Czech anti-Semitism.

In his youth in Freiberg, Jacob had experienced German anti-Semitism. He had taken it stoically as an inevitable heritage of Jewish birth, a small matter compared with the relative freedom which the Jews enjoyed in Moravia. Later, the revolution of 1848 in Bohemia, neighbor of Moravia, started with Czech riots in Prague against Jewish textile manufacturers. Hostility from both Germans and Czechs threatened the Jews, and right in Freiberg the grumbling cloth-makers got used to holding the Jewish textile merchants responsible for their plight. These rumblings did not actually threaten the life and property of the few Jewish families in Freiberg, but they were more ominous in this small and backward community than they would have been in one of the great capitals.

Finally, Freiberg did not promise educational opportunities suitable for a bright boy. It is true that in 1858 the citizens had enjoyed a partial re-opening of the high school (gymnasium) which had been closed since 1827. This poor beginning was made possible by a fund which over a period of thirty years finally had grown sufficiently to permit the establishment of the lowest grades. Slim, indeed, were the facilities for developing greatness in Freiberg.

Want of bread, of education and of freedom from persecution are the motors of emigration at all times and everywhere. Following a pogrom in Cologne, in the 14th Century, these forces had moved the ancestors of Jacob from the Rhineland East to Lithuania and from there to Poland, and then west to Moravia. So, in 1859, the Freud migration was resumed. Emanuel, with John and Pauline, went to Manchester in England. Jacob with wife, son and daughter, went to Leipzig, and from there to Vienna. There Freud lived until 1938 when the final migration to London occurred.

APPENDIX

We have placed in the hands of the editors the manuscript of an appendix containing the detailed references which authenticate each of the statements made in our paper. Due to the paper shortage we include only a brief summary of this appendix in the following paragraphs. We are ready to answer specific questions which may arise relative to these references.

The main source of our material comes from Freud's own references to his early childhood years. These occur in the following of his writings:

1. 1899 "Ueber Deckerinnerungen." *Gesammelte Schriften.* Wien, Int. Psya. Verlag, 1924. Vol. 1, pp. 473–476.

2. 1900 "Die Traumdeutung." *Ges. Schr.* Vol. II, pp. 18, 47, 171, 192, 196, 198, 206, 217, 249, 332, 354, 355, 389, 410, 414.

2-a. The Interpretation of Dreams. Transl. by A. A. Brill, in: *The Basic Writings of Sigmund Freud.* New York, Modern Library, 1938. Pp. 243, 257, 259, 261, 266, 274, 296–97, 359, 408–09, 433, 454, 505.

2-b. *The Interpretation of Dreams.* Transl. by A. A. Brill. New York, The Macmillan Co., 1913. Pp. 12, 35–36.

3. "Ergaenzungen zur Traumdeutung." *Ges. Schr.* Vol. III. Pp. 164.

4. 1904 "Zur Psychopathologie des Alltagslebens." *Ges. Schr.* Vol. IV. Pp. 58–60.

4-a. "Psychopathology of Everyday Life. Transl. by A. A. Brill, in: *The Basic Writings of Sigmund Freud.* New York, Modern Library, 1938. Pp. 67–68.

5. 1922 "Traum und Telepathie." *Ges. Schr.* Vol. III. Pp. 278–79.

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6. 1925 "Selbstdarstellung." *Ges. Schr.* Vol. XI. Pp. 120.

6-a. *Autobiography.* Transl. by James Strachey. New York, W. W. Norton & Co. Inc., 1935. P. 9.

7. 1931 "Brief an den Buergermeister der Stadt Pribor." *Ges. Schr.* Vol. XII. P. 414.

In the autobiographical material above, we list the paper "Ueber Deckerinnerungen," because in our opinion "the scholar 38 years of age" who tells vividly his life history, is a disguise for Freud himself. One of us, in a paper to be published soon, has discussed fully the pros and cons of this interpretation.—When several English translations or editions of the same work exist, we list above the one which is most easily accessible. Numbers (1) and (7) are not translated as far as we know. Number (4-a) does not contain the note of (4), p. 60, which is highly important in the context of the present paper. The material (3), p. 164 is contained in (2-a).

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BIODYNAMIC MEDICINE VERSUS PSYCHOSOMATIC MEDICINE

By IAGO GALDSTON, M.D.*

The inadequacy of the term *psychosomatic* has long been patent. The principal and most common objection against it has been that it perpetuates the very dichotomy which it was intended to obliterate. The hyphenation of psyche and soma yielded a bondage and not a fusion. This bondage is more of a verbal than of an ideological nature. It has produced, as is not uncommon to bondages, internal as well as relational stresses, and distortions. Ideologically, it not only defeats the purpose for which it was created, but fortifies the opposite. It has the quality of a true paradox and inevitably renders impossible the simultaneous and unique encompassment of soma and psyche, perpetuating not only a verbal, but a time and causality sequence in their relationship.

This is clearly witnessed by the very definition of psychosomatic medicine, which definition is as follows—

> "This is *psychosomatic medicine*, a term used to designate that department of medicine that studies the relationship of emotional problems to diseases that involve pathological changes in structure and functions of the body. It is based upon the principle that emotional tensions, chronic or acute, are often discharged in ways that upset the normal physiological equilibrium of an organ, thus initiating the somatic changes that produce disease."

The time and causality sequences between the disorders of the psyche and those of the soma are clearly indicated in this definition. First come the "emotional tensions," these are then "discharged in ways that upset the normal physiological equilibrium of an organ," and this upset leads in turn to "somatic changes that produce disease." The same time and causality relations are expressed in the "soma-psyche" aspect, as is witnessed by the accepted statement, "When an individual becomes sick he tends to regress to a lower level of personality integration." Here the person is said first to become sick and subsequently, and by implication because of his illness, to regress in personality.

That these criticisms are not founded on purely verbal considerations can furthermore be witnessed by much of the work, good work at that, which is published in the literature. Practically all of it falls into one of two categories; demonstrations that somatic disorders are traceable, sometimes in a causality, and sometimes in a relational association with psychological

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(affect) disturbances; and, demonstrations of the obverse, to wit the causational or relational association of psychological disturbances with somatic disease and disorders. We have, indeed, what amounts to two orders of demonstrations which should be labeled *somato-psychic* and *psychosomatic*, or graphically, thus: *psyche* > *soma* and *soma* > *psyche*.

The most deleterious effects of the faulty theories of "time and causality relations" are to be seen in the purely experimental, as distinguished from the clinical, psycho-somatic studies. In these studies the soma is affected by some noxious agent, or through some deleterious condition, and the results upon the psyche are observed. It is then argued, or at least implied, that the psychological effects observed are the result of the somatic disturbances produced. In some animal experiments the reverse has been attempted, establishing, it is claimed, that definite somatic changes can be produced by disturbances in the emotions of the animal. Here again one cannot quarrel with the facts reported. It is true, and has been long known, that cerebral anoxemia will alter the behavior of an individual. It is likewise known that when one frustrates, or teases an animal long enough it will "go off its food" and become sick. The real fault in such experimental studies is that being based on defective theoretical hypothesis, they pretend to prove what they cannot prove. They seldom approximate the conditions of the common reality in which human beings and animals exist. Hence, they are valid, to the extent that they are, only for those grossly artificial circumstances in which they (the experiments) were made.

There is an even more serious limitation which militates against their validity and worth. It is the limitation inherent in all pathological studies. The reactions to noxious agents of which cells, individually and in the aggregate, are capable are very limited. It is not, therefore, possible to determine by the pathology observed the precise, and *major etiology* of the condition. This is as true in a psychiatric disorder when the total behavior of the total individual is involved, as it is in the case of a small vesicle involving only a minute fraction of the whole body.*

This is not to say that the study of pathology is without value, nor that the experiments in psychosomatic relations are without worth. It is rather to set the limits of their competence to demonstrate validities of a complicated nature and to affirm that being based on defective theoretical premises they must inevitably lead to erroneous inferences.

The term psychosomatic is in effect the compromise made by this age of the heritage left it by its medical progenitors. This heritage consisted on the one hand of the vast and particularized knowledge of the structure

* The reader who, for example, believes that the discovery of a tubercle filled with the bacilli of tuberculosis, established the *whole etiology* of the case, must inevitably miss the point of the argument.

and functions of the cells, tissues, organs and systems of the animal organism, and on the other hand the less massive, but none the less impressive accumulation of psychologic and psychiatric knowledge. Each having developed with but only the most tenuous bonds with the other, it appeared timely and desirable that the two departments, medicine and psychology, should be brought within the embrace of a single discipline. Unfortunately together with the heritage of data came also the heritage of methods, and the latter have remained substantially unaffected and unaltered by their mutual approximations. On the contrary the old methodologies are not questioned but are employed to supplement and confirm one another.

It is an interesting and rather significant question as to why the methodologies of somatic (clinical) medicine and those of traditional psychology and of psychiatry have not been subjected to any fundamental critical scrutiny and reformulation.* It would seem that such a reformulation was indicated by the very history of each department. Clinical medicine has certainly been indifferent to psychology and aggressively antagonistic toward psychiatry. And being on the defensive, psychiatry has been aloof from clinical medicine. This being substantially true, it would seem necessary to investigate into the genesis of this antagonism, not only because it is in itself an interesting problem, but because such an investigation may yield knowledge useful to the efforts to blend clinical medicine and psychiatry. Little however has been done to illuminate this problem. In the histories of medicine and in those of medical psychology, in so far as this problem is treated at all, it is dealt with in terms of personalities. These are portrayed either as men who though bright in some respects were obtuse in matters psychological, or, as men who being ahead of their time and far seeing anticipated the psychological and psychiatric knowledge of the future ages. By such accounts the antagonism between medicine and psychiatry arose out of the peculiar personalities of their respective protagonists, out of the difference in their intelligences, and good will. By corollary the antagonism should be eliminated when both departments are manned by men of corresponding intelligence and good will.

Palpably such a version of the origin of the difficulties is not historically tenable nor does it explain anything. In justice to the historians it should be said that the elaboration is the authors' and not theirs. They only describe the personalities. They advance no arguments. They haven't as yet recognized the problem. But we must recognize it and carry it further. Instead of accounting for the schism between medicine and psychiatry (historically there was a schism) in terms of dominant

* Dr. Smith Ely Jelliffe, Dr. Adolf Meyer and Dr. William A. White, be it noted, *have* attempted to do this.

historical personalities, we need rather to look to the theories and methodologies. It is in these that we are most likely to find the answer to our problem. Then without stopping to describe the theories and methods, we must observe that as long as they prevail unaltered, no amount of general intelligence or good will will reconcile them. Though fostered by one brain, they will clash should that one brain attempt to make an integral of them. But, and this is important, they can be retained as a twain, and worked singly and together to advance now medicine, now psychiatry, retaining the old dichotomy, on more familiar and facile terms perhaps, but never gaining that which was intended by psychosomatic medicine.

The phenomenon itself requires some elucidation. It has its basic reasons. The dichotomous approach to the study of the living human body suits most facilely the inherent, native competence of the human intelligence. It is the way we naturally see and reason about things. It is the primitive, instinctual, and unsophisticated process of our reasoning life, geared to the elementary physiological processes and the elementary subjective perceptions in time, space and sequence relations. The psyche-soma dichotomy is just as native to our primal intellectual functions as "the rising and the setting of the sun" is to our sense experience, and the vocalization of words in a "linear sequence" is to our speech. These primitive processes are inextricably bound up with our physiological functions. Sensorially we cannot but see the sun rise and set, or the spoon half immersed in a glass of water otherwise than "broken". And natively we cannot but reason in terms of the soma and the psyche. To achieve an adequate understanding of phenomena our sensory perceptions, and our primitive data must be supplemented with derivatives drawn from grouped or conglomerated experiences. Things are then "seen" in the intellect quite differently than they are seen in crude experience. But the reformulation of the data of experience, the extraction of corrective derivatives from conglomerated experience, are difficult tasks, toward the performance of which the human intelligence is largely refractory. And that is in major part the reason why the dichotomous approach to the living human body holds sway.

The conglomeration of experience by which is intended not merely the summation, but the critical counterposition of the data of experience to the end that understanding may be advanced, and the errors inherent in isolated and singular observations may be corrected by additive data obtained from other and *different* observations, is always difficult. It is a task calling for competence and skill in dealing with many factors at one time. But difficult as it may be in the realm of the basic sciences, it is ever so much more difficult in the realm of human biology; this for the simple reason that the factors to be included are so very much more numerous, and the possible variants even more so.

The dichotomous study of the human body persists also because, as was in part indicated above, it is the only method by which it is humanly possible to obtain the crude data of experience. The fault lies in the extension of the dichotomous methodologies and theories beyond this stage to the interpretation and integration of crude data. For this different methods based on different theories are required. It is at this point that psychosomatic medicine fails.

In this respect there is no redeeming the term, or the concept, of psychosomatic medicine. It should be discarded or it should be restricted as a descriptive term applied to certain crude data. For its present-day usage the term *biodynamic* (or some more happy equivalent) should be employed.

In advancing the term Biodynamic Medicine we intend to deny the validity and to eliminate from our thinking the concept of a causality relation in either direction between psyche and soma. Instead of maintaining that *because* of emotional tensions an individual develops an ulcer, we postulate that the given individual, representing a dynamic aggregate, is affected by the forces which alter his dynamic configuration, and we witness this alteration in the totality of his being in all its relations. Again, instead of conceiving the sick individual as regressing to a lower personality level *because* of his illness, we will understand that the interplay of forces which makes the individual sick, also, and at the same time, though possibly in different degrees, effect that alteration in personality which we label "regressive".

Patently this is the holistic concept applied to medicine. It is, in a measure, what Adolf Meyer intended in the term psychobiology. In speaking of the individual as a "dynamic aggregate" or possessing a "dynamic configuration," we do not intend to join the ranks of the crass materialists, or of the unregenerate mechanists. We affirm rather that there are forces operating in the world of human beings and the realm of social relations which are "in addition" to those counted by the chemists and the physicists. But for that we do not deny, in fact embrace and include all the forces recognized by the mechanists.

In biodynamic medicine we intend then the concept and the study of the living organism, itself a dynamism, as it moves and is affected by the surrounding forces and continuously alters its configurations. We recognize that though ultimately force has a common and basic character, it is manifest in experience under many guises and in different patterns, such as physical, chemical, thermal, electrical, psychological, and social. There are numerous distinguishable embodiments of force whose dynamic effects upon the human organism are well known and recognized. These include such instances as parasites, bacteria, toxins, inorganic poisons, physical agents possessed of high momentum, extreme high or extreme low tem-

perature. Some forces operate without corporeal embodiment, as for example, suggestion, ideals, panic. The significant idea then is that the living organism conceived as a dynamism, is continuously exposed to the effects of multiform forces which surround it. The destiny of the organism, and its temporal configuration, is affected and determined by the very modifications it experiences as a result of the interplay of its own dynamism with the surrounding forces. This conception is implied in the science of metabolism. But here it is limited to the energy, (force) intake represented by the foods eaten and the energies expended in vital functions and in work. The idea of the metabolic process could be extended to embrace all the varieties of energy-exchange experienced by the organism.

The idea basic to the concept of biodynamic medicine can be illustrated by borrowing Descartes' image of "vortexes gyrating in a closed universe." More descriptive as an illustration is the type of spinning top which carries on its upper surface a number of disks so geared to each other that as the top spins they revolve and the top continuously changes its hues and colors. In this contraption the relation of the position of the colored disks to each other and the color seen on the spinning top change simultaneously. A time sequence between the change in relation of the disks and the change in the color of the spinning top is inconceivable. Likewise is it impossible to conceive of the change in the color of the spinning top as having been caused by the change in the position of the colored disks.

The advantages that can be claimed for the term biodynamic medicine, and for the concept which it labels are these: that it supplies a verbal and conceptual basis to which the particular phenomena in physiology and in pathology can be referred, and upon which they can be reduced to a common denominator. The term biodynamic faithfully and graphically reflects the actuality of the living process. The "dynamic" fraction of the term compels awareness of the continuous motility of the living organism. It makes possible the association, equation and summation of such divergent instances of force as bacteria, foods, and suggestion. It provides a basic concept-pattern as to how these varying forces can affect the living organism, altering its dynamics. It blends into a continuum the at present apposed states of health and disease, marking them off as different degrees on a conceptual scale. It facilitates the intellectual visualization of the simultaneous and multiform effects upon the living organism consequent to the operation of any force upon its dynamism.

The concept of biodynamic medicine ties together the varieties of medical experience and resolves them by a common formula.

A CASE OF ADDICTION TO DEMEROL

JEROME M. SCHNECK, M.D.

This case report deals with a patient admitted to the Clinic for addiction to demerol and pantopon (plus habituation to dilaudid and barbiturates). It is the first admission to this Clinic of a case of drug addiction involving demerol and is of special interest as the only case of spontaneous addiction to demerol so far reported in this country. In the German literature there is an article by Kucher[1] reporting two interesting cases of demerol consumption, one of which was showing withdrawal symptoms. Kucher's case and the one presented in this paper are the only two thus far reported, to the author's knowledge, of spontaneous addiction to demerol. Although its manufacturers do not disclaim the possibility of habit formation with demerol, the impression is prevalent that the drug is not habit forming.

Since the introduction of demerol (1-methyl-4-phenyl-piperidine-4-carboxylic acid ethyl ester hydrochloride, also known as dolantin and available in England under the name *pethidine*) by Eisleb and Schaumann in 1939[2], several studies have been made in connection with its morphine and atropine-like effect in various medical and surgical conditions. It has been used experimentally for the relief of post-operative pain, as a pre-anaesthetic agent in combination with scopolamine[3], as an analgesic agent in obstetrical practice, and in a variety of neurological cases from neuritides and neuralgias to tabetic crises, painful phantom limbs, headaches following lumbar punctures and post-encephalography cases[4]. Its effectiveness seems to be due to a morphine-like effect on the central nervous system in addition to an antispasmodic action attributable to a depression of the parasympathetic nerve endings and of smooth muscle directly. Clinical studies on a large number of patients have been reported by Batterman[5]. Addiction to the use of demerol has been studied mostly in addicts and post-addicts (opium, morphine, heroin) under controlled conditions[6].

CASE REPORT

The patient was a 38-year-old housewife, married but childless. She was reared in a comfortable home and educational opportunities enabled her to obtain degrees in art, music and Spanish. For many years she taught school, engaged in church work and led an active social life. As an attractive, friendly, capable person with a good sense of humor she had many acquaintances and friends.

Her medical history includes a series of five major operations within a period of thirteen years. These consist of an appendectomy, cholecystectomy, mastoidectomy, oophorectomy, and nephrectomy. In addition,

she was hospitalized repeatedly for cystoscopic examinations of which she had at least nineteen, for a spontaneous abortion two years after she was married, and for various less important complaints. The surgical history in this case is typical of the neurotic compulsion to submit to repeated operations, described by Karl Menninger[7] and called by him "polysurgical addiction."

It is known definitely that the patient was taking large doses of pantopon in 1936 while undergoing cystoscopic examinations. Thereafter she apparently used pantopon in gradually increasing doses and later on started to take dilaudid. She also took pentobarbital sodium in amounts sufficient to make her almost stuporous. She claimed to have had withdrawal reactions when pantopon was discontinued suddenly but not in the case of dilaudid. Her statements regarding the maximum doses taken and time elements involved were considered unreliable.

The patient claimed to have learned about demerol from an osteopath (whom she had consulted for back pain) who told her it was "just the thing to take, and *not habit-forming.*" It could not be obtained for her at that time, however. Later it was re-introduced to her by a pharmacist who knew about her addiction to other drugs and suggested demerol for her pain alleviation because, he claimed, it was "*not habit-forming.*" She began with a dose of 50 mgm. a day but increased the quantity and admitted that on several occasions she had taken 600 mgm. a day. It has been learned from this pharmacist that she purchased at least 1,250 mgm. a week over a three months' period from him alone. During the few months prior to her admission to our Clinic, she had a craving only for demerol.

She was admitted to this Hospital for study. Physical examination disclosed a vaginal discharge and occasional bleeding of undetermined cause. Temperature range, pulse and respiration rates, and blood pressure readings were within normal limits. Blood studies revealed a normal hemoglobin, red and white cell counts, and cell differential. The blood urea nitrogen was normal and the Kahn test was negative. The urine analysis was negative. An X-ray examination of the chest revealed, on a flat film, an old interlobar pleurisy in the right lung without any evidence of fluid. A neurological examination was essentially negative.

The patient acknowledged upon questioning that she had observed various signs and symptoms while taking demerol, regardless of the quantity. These consisted of: (1) shaking of the legs, noticed more when walking than when sitting or lying down; (2) tremors of her hands, especially the right hand, upon awakening in the morning; this would last for five minutes approximately and rubbing her hands together would help to dispel this sensation. (No tingling or crawling sensations were noticed.) (3) "A good feeling which kept me going," and which would "make me feel chip-

per"; (4) a general appearance which caused friends to observe that she looked particularly well (which had not been the case when she had relied on pantopon); (5) palpitation upon slight exertion, not observed when taking other drugs; (6) frequency of urination.

A feeling of "stiffness of the upper lip" occurred once, the patient maintained, when she took 600 mgm. within a period of eight hours. She said it felt as if she had a "novocain injection" and she felt that talking was an effort. She felt as if other people could observe that something was wrong with her lip. On this occasion she had no sense of well-being and felt fatigued. When taking 600 mgm. a day she also began to sense some dryness of her mouth.

Withdrawal symptoms occurred within 24 hours after discontinuing the use of the drug. These consisted of headaches, back pains, mild aching of the bones, some generalized body aches, a sense of fatigue, a feeling of great desire for the drug, a feeling of tenseness, and a sense of depression. These symptoms were relieved as soon as demerol was taken again.

The course in the Hospital was marked by repeated declarations of her wish to cooperate, constant straining at restrictions, and frequent weeping spells. Her manner and behavior seemed affected, and her remarks to others frequently sarcastic. She was alert and well oriented in all spheres (no drugs were being taken). Recent and remote memory were good and no perceptual defects were discovered. She had an excellent fund of knowledge with a verbal intelligence quotient of 124 and a performance I.Q. of 105.

CONCLUSIONS

Despite impressions to the contrary, addiction to demerol does occur as illustrated by the case presented. It seems likely that when demerol is used more widely, as it surely will be as soon as the supply increases, case reports of the occurrence of addiction to demerol in ambulatory cases having no analgesic requirement will appear more often. Patients should not be told that demerol is not "habit-forming."

SUMMARY

The first report in this country of a case of spontaneous addiction to demerol has been presented. It is believed to be the second case of this kind in the literature. An outline of the patient's history has stressed the features of drug addiction and a polysurgical history. A summary of the physical and mental examinations with laboratory data has been included, and the course in the Hospital mentioned. Physical manifestations appearing while the drug was being taken are listed as well as withdrawal symptoms indicative of what in recent literature has been called "physical dependence."

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Young Offenders. An Enquiry into Juvenile Delinquency. By A. M. Carr-Saunders, Hermann Mannheim, E. C. Rhodes. Price, $1.75. Pp. 168. Cambridge University Press, New York, The Macmillan Company, 1944.

This is a statistical study made under the auspices of the British Home Office, planned and begun ambitiously before the outbreak of the war, reduced in quality and quantity by the pressures of wartime. In itself the enormous amount of statistical data gathered in 1938–39 fails to teach anything of importance on juvenile delinquency. If, however, in the future, similar investigations should be made at regular and frequent intervals and conducted by similar methods, information so gained on trends and correlations might become valuable. (P. B.)

Coming of Age. By Esther Lloyd-Jones and Ruth Fedder. Price $2.50. Pp. 280. New York, Whittlesey House, 1941.

The purpose of this book is to provide "down to earth" material for young people that will be of assistance to them in their dependence-independence conflicts with their families, in their choice of school, in their social and vocational adjustments, and in their general development of a dynamic sense of values. The source material comes from personal interviews with several hundred college students, carried on in a project under the auspices of the American Council on Education. The generous quotations from the interviews emphasizing the commonality of the problems of youth, and the specific information regarding educational and vocational training and employment resources are the particular strength of the book. (L. C.)

The Navaho Door. By Lt. Alexander H. Leighton, M.D. and Dorothea C. Leighton, M.D. Price $4.00. Pp. 149. Cambridge, Harvard Univ. Press, 1944.

A careful study of the social life, the ideas, the feelings, the frustrations and the satisfactions of any minority group is always of importance to the psychiatrist. In this book, two competent authorities, both physicians, put into beautiful English a general survey of the Navaho which every psychiatrist and, for that matter, every American should read. (K. A. M.)

Infants Without Families. By Anna Freud and Dorothy Burlingham. Price $2.00. Pp. 128. New York, International University Press, 1944.

This book is offered as a practical contribution to the problems involving the care for homeless children after the war. In summary form the authors present their findings in regard to the comparative development of "residential" (institutionalized) children and children who grow up in families. The majority of the observations reported are in agreement with other psychological investigations of the "institutional child" and support the psychoanalytic view of human development.

The book is especially recommended to those interested in the practical problems of sound psychological management of children in institutions.

While the authors have not attempted a thorough theoretical evaluation of their findings, those concerned with child analysis will be interested in the illustrative case material from a theoretical point of view. (S. E.)

Managing Your Mind. By S. H. Kraines, M.D. and E. S. Thetford. Price $2.75. Pp. 374. New York, The Macmillan Company, 1944.

This is a popular presentation of the principles of psychiatry with particular reference to physical symptoms and other common manifestations likely to be encountered by the average citizen and unlikely to be recognized by him as psychiatric. The first half is more didactic, the latter half more hortatory. The first part is the better. (K. A. M.)

Psychoanalytic Orientation in Case Work. By Thomas M. French and Ralph Ormsby. Price 50¢. Pp. 51. New York, Family Welfare Association of America, 1944.

This booklet contains two articles. Doctor French in "Psychoanalysis and Social Work" presents in a particularly concise way the important principles of psychotherapy essential as minimal knowledge for the casework practitioner. "Treatment in a Dependency Situation" by Mr. Ormsby is a case presentation of a family's activity with a private family agency over a period of 32 months. The case demonstrates the practical application by the caseworker of the principles enunciated by Doctor French.

Doctor French's confidence in social workers as a developing, responsible group and his recognition of the increasing cooperation of that group with psychoanalysts in psychotherapeutic experiments may have significance for the future. (L. C.)

Religion and Health. By Seward Hiltner. Price $2.50. Pp. 292. New York, The Macmillan Co., 1943.

The author is the Executive Secretary of the Commission on Religion and Health of the Federal Council of Churches of Christ in America. Along with Smiley Blanton, Harry Bone, Otis Rice and a few others, he has done much to arouse an interest among the intelligent clergymen in the psychological and psychiatric aspects of the personality and the relation of these to the religious life of individuals and of groups. This book ably documents this point of view in a systematic description of mental hygiene, psychosomatic medicine, the function of Christianity in mental health, the function of psychiatry in religion, the religious worker and mental illness, and similar topics. (K. A. M.)

Synopsis of Neuropsychiatry. By Lowell S. Selling. Price $5.00. Pp. 500. St. Louis, C. V. Mosby Co., 1944.

This manual aims to provide a simplified, systematic coverage of neuropsychiatry for the following persons: the student who is apt to get lost in the detail of conventional medical textbooks; the practitioner who needs a quick aid in diagnosis; and the specialist who must make periodic routine reviews of his field. It is written in outline form with the following items covered for each disorder: definition, etiology, pathology, symptomatology, differential diagnosis, prognosis, and treatment. Also added are the military and medicolegal aspects of each illness. The book is written chiefly from the neurological standpoint. The author is Director of the

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Psychopathic Clinic connected with the Recorder's Court at Detroit, Michigan. (I. B. M.)

Unconsciousness. By James Grier Miller. Price $3.00. Pp. 329. New York, John Wiley & Sons, Inc., 1942.

The author of this book has made a systematic presentation of the various ways in which the word *unconscious* is used in psychological literature, describing each of these at some length, illustrating them and summarizing the present knowledge and views on each of these concepts. It is, therefore, an important reference book. (K. A. M.)

A Handbook of Psychiatry. By P. M. Lichtenstein, M.D. and S. M. Small, M.D. Price $3.50. Pp. 330. New York, Farrar & Rinehart, Inc., 1943.

In German scientific literature the equivalent of our word "Handbook" is an exhaustive treatise. In English the word is often used to mean an exceedingly condensed and necessarily superficial epitome. This volume is a handbook in the latter sense. It summarizes psychiatry, for the most part, according to concepts and practices of twenty years ago. (K. A. M.)